**IN THE MISSOURI DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION**

DIVISION OF INSURANCE COMPANY REGULATION,	)	
Petitioner,	)	
v.	)	Case No. 160325191C
AETNA INC.	)	
and	)	
HUMANA INC.,	)	
Respondents.	)	

**[PROPOSED] FINDINGS OF FACT,
CONCLUSIONS OF LAW AND RECOMMENDATION**

Based on the competent and substantial evidence on the whole record, I, Mary S. Erickson, Chief Counsel for the Insurance Division of the Missouri Department of Insurance, Financial Institutions and Professional Registration (the "Department") and the Hearing Officer for the captioned matter, find and conclude that, for the reasons set forth below, there is no substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein. Accordingly, I hereby recommend that no order should be issued pursuant to 382.095.5, RSMo.

The Form E Statement And Form E Proceeding

1. On or about October 14, 2016, Aetna Inc. ("Aetna") filed a Form E pre-acquisition notification on Form E of 20 CSR 200-11.101, entitled "Pre-Acquisition Notification Form Regarding The Potential Competitive Impact Of A Proposed Merger Or Acquisition By A Non-Domiciliary Insurer Doing Business In This State Or By An Involved Insurer (the "Form E

Filing"), pursuant to the requirements of section 382.095.3, RSMo, indicating an intention to acquire control of Humana Inc. ("Humana").

2. On November 13, 2015, the Division of Insurance Company Regulation (the "Division") sent a request for information pursuant to 382.095.3, RSMo, to Aetna (the "Initial Request"). On February 26, 2016, Aetna provided its response to the Initial Request to the Division.

3. On March 25, 2016, the Division submitted a Request for Hearing to John M. Huff, the Director of the Department. On March 25, 2016, the Director issued a Notice of Hearing and Order Appointing Hearing Officer, which set this matter for hearing on Monday, May 16, 2016. On March 29, 2016, an Amended Notice of Hearing was issued.

The Standard for Establishing Prima Facie Evidence

4. Pursuant to 382.095.4(1), RSMo,

> The director may enter an order under [382.095.5] with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein.

5. 382.095.4(2), RSMo, sets forth the market share standards for demonstrating prima facie evidence of violation of the competitive standards, which burden rests upon the director. Even where such prima facie evidence exists, however, pursuant to 382.095.4(4), RSMo, "a party may establish the absence of the requisite anticompetitive effect, based upon other substantial evidence."

The Form E Hearing

6. On May 16, 2016, a hearing was conducted in Room 520B of the Harry S Truman State Office Building. The Division was represented by Kelly A. Hopper, Esq., Legal Counsel

for the Division, and Jay B. Angoff, Esq. of Mehri & Skalet, PLLC. Aetna was represented by Steven T. Whitmer, Esq. and Timothy S. Farber, Esq. of Locke Lord LLP, and Missouri co-counsel, Charles W. Hatfield, Esq. of Stinson Leonard Street LLP. Humana was represented by Michael J. Homison, Esq. and Elena M. Coyle, Esq. of Skadden, Arps, Slate, Meagher & Flom LLP.

7. Testifying for the Department were Angela Nelson, Director of the Division of Insurance Market Regulation and the Department's chief industry liaison; and John F. Rehagen, Division Director for the Division of Insurance Company Regulation, each testifying in person.

8. Testifying on behalf of Respondents Aetna and Humana was Gregory S. Martino, Assistant Vice President, State Government Relations of Aetna, testifying in person.

9. Also presenting statements in person were Gerard Grimaldi on behalf of Truman Medical Centers, and Brad Wasser, Esq. of the Law Offices of David A. Balto, on behalf of certain consumer groups.

10. During the Hearing, the Division submitted exhibits marked 1 through 36, and Aetna and Humana submitted exhibits marked A through EE. All of the exhibits were admitted into the record. Certain of the exhibits contained confidential trade secrets and other confidential information. For the reasons stated on the record and pursuant to 610.021(14), RSMo, 382.095.3, RSMo, 20 CSR 10-2.400(3)(K)(2) and 417.453(4), RSMo, and my May 2, 2016 Order, Exhibits 8, 11, 12, A, B, C, I, J, K, N, O, P and Q were ordered to be closed records.

The Experts

The following three experts submitted oral and written testimony.

Expert 1: Dr. Thomas McCarthy

11. Dr. McCarthy is an economist and senior vice president employed by NERA Economic Consulting ("NERA"), and submitted testimony on behalf of Aetna and Humana. For over thirty years, he has specialized in the study of industrial organization and health economics, focusing principally on antitrust, intellectual property and commercial damage matters in the health care marketplace. Dr. McCarthy has testified in a variety of health care litigations. He has also analyzed the competitive effects of many hospital mergers and a wide range of health insurance mergers—such as the mergers of Cigna-HealthSpring, UnitedHealth-PacifiCare, BCBS of Michigan-M-CARE, Aetna-Prudential, Aetna-Coventry, BCBS of New Mexico-Lovelace Health Plan and Cigna-Great West. Dr. McCarthy has also testified on issues involving competition in health insurance markets. For this proposed merger, he has presented testimony to Florida's Office of Insurance Regulation and submitted affidavits to the States of Florida, Indiana and Texas. [Ex. C, McCarthy Affidavit; Ex. D, McCarthy Curriculum Vitae; McCarthy Testimony.]

Expert 2: Jonathan Orszag

12. Jonathan Orszag is a Senior Managing Director of Compass Lexecon, an economic consulting firm, and submitted testimony on behalf of Aetna and Humana. He also serves as a Senior Fellow at the Center for American Progress, a policy think-tank in Washington, D.C. Mr. Orszag is one of the leading economists in the country on whether mergers benefit or hurt consumers, and has consulted on more than one hundred different mergers. Before his current role, Mr. Orszag worked at the office of the Chief Economist of the Department of Labor, and then with the White House to serve as Economic Policy Advisor on President Clinton's National Economic Council. He also previously ran the Office of Policy and

Strategic Planning at the U.S. Department of Commerce. Mr. Orszag has received numerous awards, and was recently ranked as one of the top ten competition economists in the world. [Ex. L, Orszag Curriculum Vitae; Orszag Testimony.]

Expert 3: Jonathan Gruber

13. Jonathan Gruber is the Ford Professor of Economics at MIT, and submitted testimony on behalf of the Division. He has been studying health insurance markets for more than 20 years and has published more than 100 articles on health care and health care economics. He is also the Associate Editor of the Journal of Health Economics, Director of the Health Care Program at the National Bureau of Economic Research, and the President-Elect of the American Society of Health Economists. He has received numerous awards. [Gruber Affidavit; Gruber Testimony.]

The 17 Lines Of Insurance In The Form E

14. The Form E filing identifies a total of seventeen lines of insurance. [Ex. 11, Form E.] The Parties agreed that, with respect to the following 14 lines of insurance identified in the Form E, there is no "substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein": [1] Ordinary Life Insurance (Life and A&H Reporter ("LA&HR")), [2] Group Life Insurance (LA&HR), [3] Accident & Health Group Policies Only (LA&HR), [4] Federal Employees HBP (LA&HR), [5] Medicare Title XVIII Exempt from State Taxes or Fees (LA&HR), [6] Guaranteed Renewable Accident & Health (LA&HR), [7] All Other A&H (LA&HR), [8] Non-Renewable Stated Reasons Only (LA&HR), [9] Dental Only (Health Only Reporter ("HOR")), [10] Federal Employees HPB (HOR), [11] Medicare Supplement (HOR),

[12] Title XIX Medicaid (HOR), [13] Vision Only (HOR), [14] Disability, and Long Term Care, Stop Loss & Other ("Other") (HOR). [Ex. 11, Form E; Stipulation; Rehagen Testimony.]

15. With respect to three other lines of insurance identified in the Form E, the Parties disagree over whether "there is substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein." 382.095.4(1), RSMo. Those three lines are Comprehensive Group, Comprehensive Individual and Title XVIII Medicare (the "Three Lines"), which are each Health Only filers.

The Division's Prima Facie Case

16. The Division's witnesses and the market shares stated in the Form E established that the shares for the Three Lines exceed the thresholds set forth in Section 382.095.4(2), which therefore establishes prima facie evidence of a violation of the competitive standard. [Ex. 11, Form E; Rehagen Testimony.]

The Substantial Evidence Rebuttal Standard

17. Although the Division established its prima facie case, Missouri law allows for a party to rebut that presumption with other substantial evidence. Specifically, pursuant to 382.095.4(4), RSMo, even where such prima facie evidence exists,

> a party may establish the absence of the requisite anticompetitive effect, based upon other substantial evidence. Relevant factors in making a determination under this subdivision include, but are not limited to, the following: Market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market. (emphasis added.)

18. In addition, pursuant to 382.095.4(5), RSMo,

> An order shall not be entered under [382.095.5] if:

> (a) The acquisition will yield substantial economies of scale or economies in resource use that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or
>
> (b) The acquisition will substantially increase the availability of insurance, and the public benefits of such increase exceed the public benefits which would arise from not lessening competition.

Additional Factors And Substantial Evidence To Consider To Rebut The Prima Facie Case

19. Dr. McCarthy and Mr. Orszag presented testimony regarding other relevant factors they considered. For the reasons set forth below, I agree that these factors are relevant to the analysis and therefore should be considered under 382.095.4, RSMo.

20. Notably, many of the factors set forth in 382.095.4, RSMo. are the same or similar to factors evaluated by other governmental agencies. The U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) Horizontal Merger Guidelines ("Horizontal Merger Guidelines") lay out a methodology for analyzing mergers between competitors. [Ex. C, McCarthy Affidavit.] The Horizontal Merger Guidelines address the type of evidence the agencies consider when analyzing a transaction under, among others, Section 7 of the Clayton Act, 15 U.S.C. § 18, which is nearly identical to 382.095.4, RSMo, prohibits transactions where "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."

Factor 1: Identifying The Relevant Markets

21. The Director is required to determine the relevant product and geographical markets. 382.095.4(3)(b), RSMo.

> In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written

> insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be the state.

382.095.4(3)(b), RSMo (emphasis added).

22. However, the Director "shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the National Association of Insurance Commissioners and to information, if any, submitted by the parties to the acquisition." 382.095.4(3)(b), RSMo (emphasis added).

The Relevant Product Market

23. Similar to 382.095.4, RSMo, the Horizontal Merger Guidelines state "[t]he Agencies give weight to the merging parties' market shares in a relevant market, the level of concentration, and the change in concentration caused by the merger."[1] Within the discussion on market definition, the Horizontal Merger Guidelines state "market definition helps specify the line of commerce."[2] In the context of reviewing the lines of business associated with Missouri law, understanding the product market is important. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

24. When defining the product market, the focus is on determining the set of products that compete with each other. This means that the product market includes the products that consumers can, and do, reasonably choose between when making a purchase. Inherent in the exercise of market definition is the understanding that not all customers have to switch to rival products for these alternatives to be included in the market, but rather, just enough have to switch

[1] Horizontal Merger Guidelines, § 2.1.3 (Aug. 19, 2010), *available at* https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

[2] Horizontal Merger Guidelines, § 4.

such that the alternative products constrain the price of the products of the merging parties. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. K, Orszag Report; Orszag Testimony.]

The Relevant Geographical Market

25. Although "the relevant geographical market is assumed to be the state," 382.095.4(3)(b), RSMo, as set forth below, the Parties presented evidence concerning local markets as well. I reach the same conclusions with respect to both state and local geographical markets.

Factor 2: The Number And Strength Of Competing Firms

26. In evaluating competition within the relevant market, Missouri law provides for consideration of the "number of competitors." 382.095.4(5), RSMo. The antitrust agencies similarly consider the number and strength of competing firms. Sufficient competition from rival firms may lead the agencies to conclude that the merger is unlikely to substantially lessen competition without further analysis. To the extent that the competitive structure of the marketplace is insufficient to reach such a conclusion, the agencies typically consider additional evidence. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. K, Orszag Report; Orszag Testimony.]

27. Market shares are an initial indicator of the alternatives available in the market. However, the Horizontal Merger Guidelines also state "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of the merger. They are used in conjunction with other evidence of competitive effects."[3]

[3] Horizontal Merger Guidelines, § 5.3.

Factor 3: Potential For Entry And Expansion

28. In evaluating competition within the relevant market, Missouri law provides for consideration of the "ease of entry and exit into the market." 382.095.4(5), RSMo. If the potential for ready entry by new competitors or expansion by existing competitors constrains the behavior of the merging parties and other market participants, then their competitive effect must also be considered. The job of the economist is to analyze the market or markets impacted by the merger and make an informed inference on whether existing and potential competition is sufficient to render unprofitable any attempt by the merging parties to raise price and/or reduce quality or service. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. K, Orszag Report; Orszag Testimony.]

Factor 4: Volatility In The Marketplace

29. In evaluating competition within the relevant market, Missouri law provides for consideration of the "volatility of ranking of market leaders." 382.095.4(5), RSMo. Such volatility is directly impacted by recent changes in the marketplace. The impact of the transaction is generally analyzed through the lens of shares. While this is instructive, current shares do not reflect the dynamic changes that are currently taking place in the Missouri health insurance marketplace, such as the Affordable Care Act ("ACA") which resulted in significant changes to the Medicare program that began to be implemented in 2013, and the introduction of public exchanges for individuals in 2014. As described below, these changes reflect substantial evidence that are further enhancing competition, which protects the marketplace from any firm obtaining or exercising market power. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. K, Orszag Report; Orszag Testimony.]

Factor 5: Standard Competition Thresholds

30. The DOJ and FTC generally find that shares in the 20-30 percent range are usually not considered to signal a competitive problem. [Ex. C, McCarthy Affidavit; McCarthy Testimony.] For instance:

- When screening for high shares of providers that are coming together to form an Accountable Care Organization ("ACO"), the DOJ and FTC provide a safety zone or safe harbor for independent providers whose ACO-related share will be 30 percent or less.[4] Similarly, the DOJ-FTC Statements of Antitrust Enforcement Policy in Health Care had the same 30 percent safe harbor threshold for non-exclusive joint ventures and 20 percent for exclusive joint ventures.[5]
- With respect to market power or monopoly power in the context of monopolization cases, courts generally do not reach a finding of monopoly power based on shares "when the market share is less than about 50

[4] "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," *DOJ & FTC*, p. 7 (Oct. 20, 2011), *available at* https://www.ftc.gov/policy/federal-register-notices/ftc-doj-enforcement-policy-statement-regarding-accountable-care ("For an ACO to fall within the ***safety zone***, independent ACO participants that provide the same service (a "common service") must have a ***combined share of 30 percent or less*** of each common service in each participant's PSA, wherever two or more ACO participants provide that service to patients from that PSA"). (Emphasis added; footnote omitted.)

[5] "Antitrust Safety Zones," Statements of Antitrust Enforcement Policy in Health Care, *DOJ & FTC*, pp. 64-65 (Aug. 1996) ("[T]he Agencies will not challenge, absent extraordinary circumstances, an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less…a non-exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market").

percent."[6] Similarly, courts have upheld mergers with shares in excess of 35 percent.[7]

31. When considering these and the other additional factors set forth in 382.095.4, RSMo, and below, I find that Aetna and Humana have presented substantial and persuasive evidence rebutting the prima facie evidence with respect to each of the Three Lines.

Line One: Comprehensive Group

32. Aetna's Missouri Form E reports a total 2014 post-merger share of 27 percent for Comprehensive Group, with 23.66 for Aetna and 3.33 for Humana. [Ex. 11, Form E.]

33. Mr. Rehagen testified that he analyzed these shares to confirm that they exceeded the thresholds set forth in Section 382.095 for establishing prima facie evidence of a violation of the competitive standard. In addition, Mr. Rehagen testified concerning historical market concentrations, which purported to provide further prima facie evidence of a violation. Mr. Rehagen confirmed, however, that once this prima facie violation was established, he took no further analysis to consider other relevant factors pursuant to Section 382.095. [Rehagen Testimony.]

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[6] ABA Section of Antitrust Law, Antitrust Law Developments, Sixth Edition (2007), Volume I, pp. 230-232 ("[M]any lower courts continue to regard defendant's market share as the starting point in assessing whether it possesses monopoly power, while others consider market share and entry barriers simultaneously. A market share in excess of 70 percent generally establishes a prima facie case of monopoly power, at least with evidence of substantial barriers to entry and evidence that existing competitors could not expand. In contrast, ***courts virtually never find monopoly power when market share is less than about 50 percent.*** The greatest uncertainty exists when market shares are between 50 percent and 70 percent"). (Emphasis added; footnotes omitted.)

[7] *See, e.g., U.S. v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1123 (N.D. Cal. 2004) ("[A] presumption of anticompetitive effects from a combined share of 35 percent in a differentiated products market is unwarranted."); *U.S. v. SunGard Data Sys., Inc.*, 172 F. Supp. 2d 172 (D.D.C. 2001) (denying plaintiffs' request for injunctive relief despite merged firm occupying no less than 35 percent of the relevant market).

34. I find that consideration of the further evidence presented by Aetna and Humana is warranted.

35. For example, considering the thresholds applied by other agencies and the courts, because the 27 percent total share is below the 30 percent threshold set forth above, and because only 3 percent of this share is attributable to Humana, this market share is unlikely substantially to lessen competition in this state. [Ex. C, McCarthy Affidavit; McCarthy Testimony.] The Division did not present evidence to the contrary. [Nelson Testimony; Rehagen Testimony; Gruber Testimony.]

The Importance Of Self-Insured Offerings

36. When the self-insured offerings are considered, the lack of competition concerns is further established.

37. Comprehensive Group premium as stated in the Health Annual Statement Blank [Ex. 15] does not capture the important competitive constraint imposed by self-insured offerings. [Ex. C, McCarthy Affidavit; McCarthy Testimony.] Many employers have the option to self-insure in addition to the fully-insured option that is being measured for the set of products reported in the Comprehensive Group line of business. For a self-insured plan, an insurer or a third-party administrator ("TPA") performs the administrative tasks, like claims processing, provider network access and pricing, while the employer picks up the actual cost of the members' healthcare expenses.[8] The employer pays a fee for the administrative services but not a premium, since the employer bears the risk for actual medical costs used by its employees. For

[8] The employer will typically also purchase stop-loss insurance to protect it from at least some portion of health care expenses that exceed expected levels. While stop-loss insurance protects the employer from catastrophic medical costs, employers typically do not purchase stop-loss insurance starting at expected medical costs.

a fully-insured plan, there are three major components to the premium: the expected medical costs, the cost of administering the plan, and a risk factor in case the actual medical costs exceed expectations. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

38. A customer choosing between a self-insured plan and a comparable fully-insured plan may find that the fully-insured premium is higher than the sum of the self-insured administrative fee, the employer's expectation of medical costs and stop-loss insurance. That price differential largely reflects the fact that even with the stop-loss insurance the self-insured employer, not the insurer, is still taking the risk for medical costs.[9] Among the factors that can impact the decision on which product to purchase, the employer has to decide whether it wants to take on the medical cost risk or possibly pay more by passing the risk on to the insurer and by paying for added mandated benefits in a fully-insured plan. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

39. Knowing that employers have the option of self-insured plans is one of the factors that ensures that the price and quality of fully-insured plans remain competitive. Even with the medical risk, most firms with more than 50 employees consider self-insurance as an option and almost all firms with more than 1,000 employees purchase self-insured products.[10] [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

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[9] There are other components of cost to consider. Fully-insured products are subject to state premium taxes and an ACA Health Insurance Providers Fee. Fully-insured plans are also subject to state mandated benefits that may be able to be avoided by a self-insured plan, thereby raising the price of the fully-insured plans relative to self-insured.

[10] An analysis by the Employee Benefit Research Institute ("EBRI") found that nationally, about 68 percent of employees working for private sector firms with 50 or more employees were in self-insured plans and over 85 percent of employees working for private sector firms over 1,000 employees. *See* https://www.ebri.org/pdf/notespdf/EBRI_Notes_06_June15_SI-AutoIRAs.pdf ("EBRI Study").

40. Since self-insured plans compete with fully-insured plans, enrollment for both funding types should be analyzed together.[11] HealthLeaders-Interstudy ("Interstudy") does report membership for both fully-insured and self-insured membership, which enables an analysis of the competitive landscape for total commercial insurance more appropriately. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

41. Based on Interstudy data, the combined firm will have a share of about 24 percent of all commercial membership. [Ex. C, McCarthy Affidavit; McCarthy Testimony.] While a 24 percent share is a prima facie violation of 382.095.4, it is within the DOJ/FTC safe harbor zone and below the level that typically suggests further analysis is warranted. [Ex. C, McCarthy Affidavit; McCarthy Testimony.] Moreover, Humana only accounts for 1.4 percent. Thus, Humana has not been a substantial competitive constraint on Aetna in Missouri. UnitedHealth, Anthem, BCBS of Kansas City and Cox Health all have more commercial enrollment in Missouri than Humana. After the transaction, just like before the transaction, UnitedHealth, Anthem and Aetna will each have a share in the 23 to 24 percent range. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

42. By including self-insured customers, the Interstudy data presents a more complete picture of the marketplace than the Form E data. However, Interstudy does not break out individual insurance from group insurance. Despite this omission, the Interstudy data likely does not create any problems analyzing the impact of this transaction in the Commercial Group segment. As the Form E data show, the combined firm's 2014 share of the individual segment is higher than its share in the group segment. Thus, it is likely that the actual share of all group

[11] As mentioned above, the shares reported in the Form E do not capture self-insured business.

customers, both self- and fully-insured, is lower than 24 percent share. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

A Review Of The Fully-Insured Commercial Group Segment

43. The Missouri DOI provides publicly available data that offer a more detailed view of the state's fully-insured Commercial Group segment. With these data, Dr. McCarthy was able to analyze fully-insured membership for small group and large group separately. While these data suffer the same flaw as the Form E data, breaking the analysis into two segments does give some additional insight into the Commercial Group segment. For small group business, relying solely on fully-insured membership does not pose a major shortcoming, since most small groups choose fully-insured plans. With about 70 percent of private sector employees that work for large groups receiving health insurance from a self-insured plan, the large group picture is very incomplete.[12] However, as mentioned above, Humana's membership is disproportionately in fully-insured plans, which means that an analysis like this that is based solely on fully-insured membership will tend to overstate Humana's presence in the large group segment.[13] [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

A Review Of The Small Group Segment

44. For small group, the combined firm will have just under a 20 percent share. Humana's presence in the small group segment is relatively small, with a share of six percent. A combined share of 20 percent, with only a modest increase from Humana leaves the structure of

[12] EBRI Study, p. 9.

[13] The EBRI study shows 60 percent of employees working for public sector firms are in self-insured plans, while only about 13 percent of Humana's membership is in self-insured plans. The study also finds that among large groups generally, about 70 percent of employees are in self-insured plans. By contrast, only about 40 percent of Humana's large group membership is in self-insured plans.

the small group segment fundamentally unchanged. There will continue to be sufficient competitors in the small group segment to ensure competition. For example, Anthem, UnitedHealth and BCBS of Kansas City are all bigger than either Aetna or Humana and, post-merger, Anthem and UnitedHealth will still be larger than the new Aetna. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

A Review Of The Large Group Segment

45. Even with Humana's presence in the fully-insured large group segment overstated, Humana only has a share slightly above one percent in that segment. In addition, the combined share will be less than 23 percent, still smaller than Anthem and UnitedHealth. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

46. The data discussed above all have limitations that likely lead to an overstatement of the combined share of the Aetna and Humana. But even with these flaws, all three analyses are consistent in estimating that the combined share in the group segment will be below 30 percent and that Humana's presence is small in the segment, leaving the structure of the marketplace intact. Furthermore, these data are consistent in showing that there are sufficient competitors to ensure competition post-merger. All of these analyses show that Aetna will not have a share high enough to raise any competitive concerns in any segment of the Commercial Group business line. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Evaluation Of Local Geographical Markets

47. Finally, as discussed above, when performing the competition analysis, "the relevant geographical market is assumed to be the state." 382.095.4(3)(b), RSMo. While the Division presented some evidence concerning market shares of the combined firm at the county level, the Division did not present substantial evidence demonstrating that the relevant

geographical market for the Comprehensive Group line of business is any particular county. Dr. McCarthy did provide competent testimony demonstrating that the relevant geographical market would be the state, or alternatively, other localized markets, expressed as metropolitan areas or micropolitan areas. Dr. McCarthy nevertheless reviewed these localized markets and confirmed that such a review does not present any competition concerns. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

48. Based on this evidence, I find that there is other substantial evidence that establishes the absence of the requisite anticompetitive effect and that, therefore, there is no substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in Comprehensive Group line of insurance in this state or tend to create a monopoly therein.

Line Two: Comprehensive Individual

49. Aetna's Missouri Form E reports a total 2014 post-merger share of 42.02 percent for Comprehensive Individual, with 41.13 percent for Aetna and 0.91 percent for Humana. [Ex. 11, Form E.]

50. Mr. Rehagen testified that he analyzed these shares to confirm that they exceeded the thresholds set forth in Section 382.095 for establishing prima facie evidence of a violation. In addition, Mr. Rehagen testified concerning historical market concentrations, which purported to provide further prima facie evidence of a violation. Mr. Rehagen confirmed, however, that once this prima facie violation was established, he took no further analysis to consider other relevant factors pursuant to Section 382.095. [Rehagen Testimony.] I find that consideration of the further evidence presented by Aetna and Humana is warranted.

Other Substantial Evidence Of Sufficient Competition

51. Further evidence establishes, however, that, for at least five reasons, the 42 percent combined share for 2014 that was reported in the Form E does not indicate a competition problem in 2016 or beyond. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

52. First, Humana has had a very small share of the segment throughout 2014 through 2106 and has not been a material competitive constraint in this segment. Second, for many consumers, the biggest impact of the Affordable Care Act ("ACA") was the introduction of public exchanges for individuals in 2014, which introduced substantial volatility into the individual segment. The more volatile the marketplace, the less significant is a firm's share in a single year – and particularly in the first year that public exchanges existed. Third, shoppers on the public exchanges are particularly price-sensitive, which means that any firm that tries to raise prices will likely lose market share. Fourth, in Missouri, price-constraining competition in the commercial individual segment – and in the public exchange segment in particular – benefits from the presence of at least four players besides Aetna and Humana. Finally, competition in this segment further benefits from the existence of additional firms that have entered public exchanges in other states and could do so rapidly if they saw attractive opportunities in Missouri. There is no reason to conclude that Humana's presence materially constrains pricing, or offers other competitive benefits not already provided by the other existing firms or potential entrants. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Volatility Of The Public Exchange

53. While the combined share in the individual segment was 42 percent in 2014, Humana contributed little with a share of about one percent. In 2014, the shares in the individual segment were heavily driven by new membership signing up through the ACA public exchange.

However, Humana did not offer an exchange product in 2014. While that plays an important role in why Humana's share was so low in 2014, Humana's position has not changed dramatically since 2014 despite Humana entering the Missouri ACA public exchange marketplace in 2015. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

54. In 2016, about 290,000 Missourians signed up for the public exchange, but Humana only has about 14,000 of those enrollees, which is less than 5 percent. Furthermore, Humana is on the exchange in only 7 of the 115 counties in the state.[14] While Aetna also participates on the exchange in all 7 of the Humana counties, in 2016, they are never both positioned in the top-2 price slots; thus, there are competitors well-positioned to undercut them in these seven counties. Statewide, Humana has not been an economically significant competitor in the commercial individual. At least four firms will remain after the transaction, which is sufficient to ensure competition on the public exchange in Missouri for the reasons discussed below. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

55. In addition, the individual segment is particularly volatile because the public exchanges are new and unsettled. Experience on the exchange shows that there can be large share swings in membership from year-to-year. For example, Aetna's membership on the exchange went from about 85,000 members in 2014 to about 125,000 in 2015, and, now, is likely to fall back to 90,000 members in 2016. When factoring the growth in membership on the exchange, this leads to Aetna's share falling from 72 percent in 2014 to about 32 percent in 2016. Because shares can shift quickly, shares in such a marketplace do not reflect sustained market power and are typically discounted in a competitive analysis. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

[14] By contrast, Aetna participates on the exchange in all 115 counties.

Consumer Price Sensitivity On The Exchange

56. The volatility described above is not just because the exchange is new; it is also because of the price sensitivity of the enrollees. About 86 percent of the members on the exchange receive subsidies from the government, due to their low-income status.[15] The subsidy is tied to the price of the second-lowest cost "silver" product offered in each county. Therefore, the plans with the two lowest prices are positioned to get the largest percentage of the premium covered by the subsidy and, thus, are positioned to get a significant proportion of the membership. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

57. In 2015, the pricing played in Aetna's favor, as it had at least one of the top-2 price positions in more counties than any other issuer. However, Aetna's price position deteriorated in 2016. As a result, Aetna's membership will likely fall from over 125,000 to under 90,000. That decline is much larger than the 11,000 or so members that Humana appears to have gained. These types of swings in membership, when tied to price, show both how fluid competition is and how sensitive the consumers are to price. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Competition On The Exchange

58. Furthermore, a combined Aetna and Humana will continue to face significant competition on the Missouri public exchange. Anthem, Cigna and BCBS of Kansas City all participated on the 2016 exchange. Anthem in particular had a strong competitive positions and

[15] Kelsey Avery, "*Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace*," October 30, 2015, *Dep't of Health & Human Services, Office of the Assistant Secretary for Planning & Evaluation*, p. 1, *available at* http://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace (accessed 11/20/2015).

was number #1 or #2 in price in the most counties. Aetna was third on that critical measure, while Humana was fifth. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

59. Competitive entry is also possible. Just as Humana entered the Missouri exchange marketplace in 2015, others could enter in the near future. For example, Centene has aggressively entered the exchanges in many states in which it has a Medicaid plan. In Missouri, Centene is a joint venture partner with Home State Health Plan, one of the three Medicaid plans in the state. In addition, Centene is on the public exchanges in neighboring states, Illinois and Arkansas. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

60. Humana's relatively low share and small footprint on the Missouri exchange in 2016, the volatility shown in the first three years of the public exchange, the price sensitive nature of the enrollees in this segment, the significant competitors that the new Aetna will face, and the potential for entry are all indicators that Aetna will not be able to impose an anticompetitive price increase and continue to succeed in the individual segment. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Evaluation Of Local Geographical Markets

61. Finally, as discussed above, when performing the competition analysis, "the relevant geographical market is assumed to be the state." 382.095.4(3)(b), RSMo. While the Division presented some evidence concerning market shares of the combined firm at the county level, the Division did not present substantial evidence demonstrating that the relevant geographical market for the Comprehensive Individual line of business is any particular county. Dr. McCarthy did provide competent testimony demonstrating that the relevant geographical market would be the state, or alternatively, other localized markets, expressed as metropolitan areas or micropolitan areas. Dr. McCarthy nevertheless reviewed these localized markets and

confirmed that such a review does not present any competition concerns. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

62. Based on this evidence, I find that there is other substantial evidence that establishes the absence of the requisite anticompetitive effect and that, therefore, there is no substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in the Comprehensive Individual line of insurance in this state or tend to create a monopoly therein.

Line Three: Title XVIII Medicare

63. Using 2014 data, there is a total of 49.53 percent for the XVIII Medicare line, with Aetna having a 31.49 percent share and Humana having an 18.04 percent share. [Ex. 11, Form E.]

64. Mr. Rehagen testified that he analyzed these shares to confirm that they exceeded the thresholds set forth in Section 382.095 for establishing prima facie evidence of a violation. In addition, Mr. Rehagen testified concerning historical market concentrations, which purported to provide further prima facie evidence of a violation. Mr. Reghagen confirmed, however, that once this prima facie violation was established, he took no further analysis to consider other relevant factors pursuant to Section 382.095. [Rehagen Testimony.] I find that consideration of the further evidence presented by Aetna and Humana is warranted.

Inclusion of Traditional Medicare In The Relevant Product Market

65. With respect to analyzing the competitive impact of the transaction on Medicare beneficiaries, the unrebutted evidence established that it is appropriate to include Traditional Medicare ("TM") with Medicare Advantage ("MA") products. When including TM, using 2014 data, there is a total of 14.4 percent for the XVIII Medicare line, with Aetna having a 8.4 percent

share and Humana having a 6.0 percent share. [Ex. 11, Form E.] This is far below the 30 percent threshold that, as discussed above, is necessary to even potentially present a competitive concern. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

The Florida OIR Consent Order

66. Florida's Office of Insurance Regulation ("Florida OIR") recently concluded that MA and TM are direct competitors, applying similar standards to those required in Missouri. [Ex. E, Consent Order; Ex. C, McCarthy Affidavit; McCarthy Testimony.] Florida OIR reached that conclusion based on many of the factors described above. In Florida OIR's words, these factors include:

- "Market Fluidity," citing the switching between MA and TM.
- "Market Dynamic," citing the fact that MA benefits are richer than TM.
- "Value Proposition," citing, among other things, the change in MA penetration over time and how it ebbs and flows depending on the cost and benefits of MA based upon changes in CMS subsidies.
- "The Future of Medicare," citing changes directed by Congress that are driving product design and management of medical care closer together.
- "The Consumer Experience," citing the CMS website that "provide a direct comparison of Medicare Advantage plans and TM."

[Ex. E, Consent Order; Ex. C, McCarthy Affidavit; McCarthy Testimony.]

67. The testimony and empirical evidence submitted by Dr. McCarthy and Mr. Orszag strongly support the conclusions of the Florida OIR.

The Similar Options Presented To Medicare Beneficiaries

68. Beneficiaries eligible for Medicare may choose to obtain insurance coverage for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care (Part A) and for certain doctors services, outpatient care, medical supplies, and preventive services (Part B) either through TM or from a private insurer offering a MA plan.[16] Enrollees in TM may supplement their coverage with (1) Medicare Supplemental policies (sometimes called Medigap plans), which help pay some of the health care costs that TM does not cover, like copayments, coinsurance, and deductibles, and/or (2) stand-alone Prescription Drug Plans ("PDP"), which provide insurance coverage for prescription drug purchases. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. Q, Shopping for Medicare Based Healthcare Coverage.]

69. Both of these coverages are offered by private insurers and are offered as individual policies as well as through a group policy.[17] MA plans are sold to individual beneficiaries and to group purchasers such as private- and public-sector employers and labor unions. MA plans for both individuals and groups typically offer additional cost coverage, as well as prescription drug coverage, as part of the service bundle. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. Q, Shopping for Medicare Based Healthcare Coverage.]

[16] *See* CMS, "Your Medicare coverage choices," *available at* https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/your-medicare-coverage-choices.html. Step 1 in signing up for Medicare is choosing between TM and MA.

[17] Employers also have the option of choosing a plan for their retired employees that is built off of TM and then cover the out-of-pocket costs through Medicare supplemental products and prescription drug (Part D) coverage. For a discussion of the options for employers, see for example, http://kff.org/report-section/retiree-health-benefits-at-the-crossroads-overview-of-health-benefits-for-pre-65-and-medicare-eligible-retirees/. Another option is to use a private exchange.

70. Medicare beneficiaries may choose from a menu of plans that vary in their premiums, their network offerings, and coverage options. Medicare beneficiaries looking for a listing of options to choose from can use CMS's on-line Plan Finder to identify the plans available in their area with the various benefit options, each plan's star rating, and an estimate of annual health care costs under each option. Plan Finder presents the beneficiary with a list of options that includes "Original Medicare" at the top, then a list of the MA options.[18] [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. Q, Shopping for Medicare Based Healthcare Coverage.]

The Age-In Decision Of Beneficiaries

71. Most Medicare beneficiaries face this choice, initially, when they "age in" and first become eligible. On an annual basis, Medicare beneficiaries can revisit their choice, and either switch among MA plans or switch into or out of TM during the open enrollment period in November and December. This annual choice for beneficiaries between TM and MA plans ensures competition on an annual basis. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

72. Both TM and MA plans require the beneficiary to pay for Medicare Part B coverage, which is available at a heavily subsidized premium.[19] As mentioned above, because TM does not cover certain costs, including prescription drugs, many enrollees choose to supplement TM with a Medigap policy and/or a PDP plan, which is also available at a subsidized premium. MA plans cover many of the same costs, including prescription drugs, and typically

[18] *See*, https://www.medicare.gov/find-a-plan/. Medicare beneficiaries can also search and compare MA plans and stand-alone PDP plans on other websites. *See, e.g.*, http://medicare-advantage-plans.healthgrove.com/ and https://www.healthpocket.com/medicare/.

[19] Medicare beneficiaries can elect not to enroll in Medicare Part B, but if they make that choice, they will not be able to enroll in MA or in a Medicare Supplemental plan.

have lower total premiums, but may have higher copayments than for beneficiaries who choose Medicare Supplemental coverage. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

73. Also, MA plans usually offer restricted physician and hospital networks in order to lower provider costs, while TM has no network restrictions. MA plans may also require pre-approval for some procedures, as is typical of HMO and some PPO products. Therefore, the enrollee is typically making a choice between lower monthly premiums with less provider choice and higher monthly premiums with more choice, fewer limits on the care received and lower copayments. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Statistics On Choices

74. In the state of Missouri, about 73 percent of the 1.1 million Medicare-eligible beneficiaries elected TM coverage in 2016. The remaining 300,000 thousand beneficiaries (or approximately 27 percent) elected an MA plan. The majority of MA enrollees (81 percent in Missouri in 2016) chose an individual MA plan, while about 11 percent enrolled in a group MA plan. Enrollees that meet certain conditions (e.g., live in an institution like a nursing home, are dually eligible for Medicare and Medicaid, or suffer from certain chronic and debilitating illnesses) may choose a Medicare SNP, accounting for the remaining 8 percent of MA enrollees.

TM's Competitive Constraint On MA

75. As the selection process suggests, the presence of TM acts as a substantial competitive constraint on MA plans. This conclusion follows from the fact that, in order to attract new enrollees and to retain existing enrollees, MA providers must offer plans that are sufficiently inexpensive and attractive such that they are viewed as preferable to both TM and other MA providers. For new beneficiaries aging into Medicare, the placement of TM at the top of the options list on CMS's Plan Finder website is a clear indication of the "target" of this

competition – the MA plans must be attractive enough to win the beneficiary away from the TM program. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

76. Furthermore, MA plans cannot offer different pricing or benefits for existing MA enrollees and the new Medicare enrollees they compete to win over to their plans. Therefore, the competitive process that exists when a beneficiary is first choosing a Medicare plan continues to protect those already enrolled in an MA plan each year during the annual enrollment period, when the Medicare beneficiary has the ability to choose a new plan, whether TM or a competing MA plan. Thus, this protection holds whether or not an existing beneficiary actively shops for a new plan, since there is consistent competition for new beneficiaries aging-in every year. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

The Supporting Empirical Evidence

77. Mr. Orszag conducted empirical analyses of data specific to Missouri, which confirmed that TM and MA should be considered part of the same market when evaluating this proposed transaction. That empirical analysis demonstrated that TM, combined with the option of a Medicare Supplemental and a Prescription Drug Plan, would constrain any theoretical unilateral exercise of market power with respect to MA plans. [Ex. K, Orszag Analysis; Orszag Testimony.]

78. In support of his findings, Mr. Orszag confirmed that TM currently accounts for 72 percent of individual Medicare enrollment in Missouri. Conversely, Aetna and Humana account for just 14 percent of individual Medicare enrollment. In addition, there are several other MA providers operating in the state. As a result, Medicare beneficiaries in Missouri have a variety of attractive options available to them. [Ex. K, Orszag Analysis; Orszag Testimony.]

79. Mr. Orszag provided empirical evidence establishing competition between TM and MA by the switching patterns of existing MA members. An analysis of 2013-2015 individual switching data from Aetna and Humana shows that, for beneficiaries living in Missouri, switching to TM from an Aetna or Humana MA plan is relatively common. Approximately 17 percent of Aetna MA enrollees who switched away from Aetna chose to enroll in TM. Similarly, approximately 19 percent of Humana MA enrollees switching away from Humana chose TM. This indicates that TM is a valuable option for beneficiaries with an MA plan and, therefore, an important form of competition with MA plans. Of course, the proposed transaction will have no impact on TM in Missouri; TM will remain a competitive constraint on the merged firm. [Ex. K, Orszag Analysis; Orszag Testimony; Ex. C, McCarthy Affidavit.]

80. In addition, Mr. Orszag presented information concerning "diversion ratios" between Aetna and Humana in Missouri. A diversion ratio is the fraction of unit sales lost by the first product due to an increase in its price that would be diverted to the second product. With respect to areas in Missouri containing significant overlap, diversion from Aetna to Humana ranges from 13-20 percent and diversion from Humana to Aetna ranges from 20-28 percent. These diversion ratios are lower than the diversion ratios from Aetna and Humana to TM. The diversion ratio from Aetna to TM ranges from 41-61 percent, while the diversion ratio from Humana to TM ranges from 37-56 percent. TM is therefore a closer substitute to the MA offering of Aetna or Humana than the MA offerings of Aetna and Humana are to each other. These data further demonstrate the significant competition between MA and TM. [Ex. K, Orszag Analysis; Orszag Testimony.]

Competitive Constraint By Other MA Plans

81. In addition to TM, other MA plans will also constrain Aetna, post-merger. UnitedHealth and Essence Health will continue to be strong competitors in Missouri. According to management for both Aetna and Humana, Essence Health is a particularly strong competitor in the St. Louis area, where it has the lowest rates and richest benefits. Essence Health has also recently expanded its offerings to include Southwest Missouri, where it offers a co-branded product with Cox Health Systems, one of two hospital systems throughout the Southwest Missouri region. Essence Health also provided the backroom support for BCBS of Kansas City's 2016 entry into the MA marketplace. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

82. Post-merger, Aetna will have the largest share of any MA insurer but that share, when considering both MA and TM, will only be about 14 percent of the Medicare membership in Missouri. As explained above, shares that are this low are not generally considered to be an antitrust concern. The large number of other coverage options for beneficiaries to choose from, whether TM or another MA plan, act as a strong deterrent to Aetna attempting to raise prices above competitive levels. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

Entry And Expansion In The MA Marketplace

83. The MA marketplace has also seen recent entry and expansion. In addition to BCBS of Kansas City's entry and Essence's expansion, Humana introduced MA plans into the St. Louis area in 2012. Cigna also entered Missouri in 2016. Anthem, a national insurer with the largest commercial plan in the state, is only a small player in Missouri MA, but is poised to expand, if it sees an opportunity. Anthem's proposed merger with Cigna may expedite that entry, as Cigna brings its HealthSpring MA expertise into Anthem. Centene is another potential entrant. Centene recently agreed to purchase HealthNet, an insurer in the west that offers a full

range of products. Centene has explicitly stated that it plans to use the HealthNet Medicare platform to expand its MA reach.[20] Centene has entered the MA space in other states and has a Medicaid product in Missouri that could quickly serve as the springboard for a new MA plan. In addition, Mercy Health System in Springfield has already filed to enter the MA segment in 2017. This recent entry and expansion activity suggests that there are low barriers to MA entry and expansion. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. O, Individual Medicare Advantage Plans: Entry Analysis.]

84. Finally, since 2010 the number of Medicare beneficiaries in Missouri who have chosen to enroll in MA plans has increased from 203,000 to about 344,000 in 2016. The penetration rate has also increased from about 20 to about 30 percent. This 10 percentage point increase in penetration is consistent with the national increase of about 8 percentage points over the same time period. Nevertheless, the majority of Medicare enrollees are still choosing TM, which indicates that it is a significant constraint on MA plans. This growth of MA relative to TM is evidence both that the MA marketplace is a highly competitive growth opportunity for health plans, and that it continues to compete successfully with TM for membership. There is no reason to expect the transaction to change these important competitive dynamics. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

[20] As stated in its July 2, 2015 press release announcing its merger with Health Net, Centene "believes that Health Net's high quality Medicare platform, including its presence in Medicare Advantage, has the potential to be applied across the combined business thereby enhancing the growth strategy." *See* "Centene to Combine with Health Net in Transaction Valued at Approximately $6.8 Billion", July 2, 2015, Centene Corporation Press Release, *available at* http://phx.corporate-ir.net/phoenix.zhtml?c=130443&p=irol-newsArticle_Print&ID=2064410 (accessed 2/23/2016).

Evaluation Of Local Geographical Markets

85. As discussed above, when performing the competition analysis, "the relevant geographical market is assumed to be the state." 382.095.4(3)(b), RSMo. While the Division presented some evidence concerning market shares of the combined firm at the county level, the Division did not present substantial evidence demonstrating that the relevant geographical market for the Title XVIII Medicare line of business is any particular county. Dr. McCarthy did provide competent testimony demonstrating that the relevant geographical market would be the state, or alternatively, other localized markets, expressed as metropolitan areas or micropolitan areas. Dr. McCarthy nevertheless reviewed these localized markets and confirmed that such a review does not present any competition concerns. [Ex. C, McCarthy Affidavit; McCarthy Testimony.]

86. Although the Division's expert, Dr. Gruber, gave a considerable amount of testimony concerning the Medicare line of insurance, his testimony was not specific to the Missouri market and did not rebut any of the findings above, which are all supported by substantial evidence. [Gruber Testimony; Ex. 34, Gruber Affidavit.]

87. Based on this evidence, I find there is other substantial evidence that establishes the absence of the requisite anticompetitive effect and that, therefore, there is no substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in Title XVIII Medicare line of insurance in this state or tend to create a monopoly therein.

The Division Submitted No Rebuttal Testimony

88. The Division did not present testimony rebutting the testimony and factual findings of Dr. McCarthy and Jonathan Orszag. First, Angela Nelson, Director of the Division of Insurance Market Regulation, confirmed that she is not an economist, had not read and had no

basis to rebut the testimony and findings of Dr. McCarthy and Mr. Orszag, and had not done any analysis on whether the proposed transaction may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein. [Nelson Testimony.]

89. Second, John F. Rehagen, Director of the Division of Insurance Company Regulation, confirmed that he too is not an economist, and had not read and had no basis to rebut the testimony set forth in the reports of Dr. McCarthy or Mr. Orszag. Instead, Mr. Rehagen confirmed that the Division had retained MIT professor, Dr. Jonathan Gruber, to respond to the testimony of Aetna's experts. [Rehagen Testimony.]

90. The expert testimony of Dr. Gruber in no way undermines the factual findings set forth above. As a starting point, Dr. Gruber testified to his lack of experience analyzing the impact of mergers on competition. [Gruber Testimony.] In addition, Dr. Gruber confirmed that "[a] full determination of the competitive effect of MA mergers is beyond the scope of [his] analysis." [Gruber Testimony; Ex. 34, Gruber Affidavit.]

91. Dr. Gruber confirmed that he did not purport to analyze the competitive effects of the proposed transaction on the state of Missouri. [Gruber Testimony.] He further testified that he has not performed any independent empirical analysis with respect to this transaction and, specifically, did not perform any such analysis to test how much of a constraint TM is on MA. [Gruber Testimony.] Dr. Gruber did not present any comments on the expert reports of Jonathan Orszag or Dr. McCarthy and had not reviewed Mr. Orszag's paper until just before his testimony at the hearing. [Gruber Testimony; Ex. K, Orszag Report; Ex. C, McCarthy Affidavit.] In addition, Dr. Gruber had not reviewed the Form E, nor was he familiar with the term "Form E." [Gruber Testimony.] With respect to the articles on which Dr. Gruber relied for his report, nearly all of them were based on outdated data, and none of them concerned this transaction or

the analysis of data specific to Missouri. [Gruber Testimony.] Given the limited scope of Dr. Gruber's analysis, I do not find that his conclusions in any way undermine those of Dr. McCarthy or Mr. Orszag.

Benefits of the Transaction Synergies on Consumers

92. Finally, pursuant to 382.095.4(5), RSMo, an order shall not be entered under [382.095.5] if:

> (a) The acquisition will yield substantial economies of scale or economies in resource use that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition . . .

93. Aetna's unrebutted testimony establishes that this transaction will provide substantial benefits to consumers. Aetna has identified several categories of efficiencies which it expects to achieve from the merger. Starting with $236 million in expected efficiencies in 2016, the recurring efficiencies from this transaction are expected to rise to $1.25 billion in 2018.[21] The 2018 figure includes efficiencies associated with selling, general and administrative expenses ("SG&A Efficiencies") and efficiencies associated with medical costs ("Medical Cost Efficiencies"). [Martino Testimony; Ex. C, McCarthy Affidavit; McCarthy Testimony.] These efficiencies were presented to the Aetna Board of Directors ("Aetna Board") as a basis for approving the transaction, which is testimony to the confidence that Aetna management has in its ability to achieve these savings. [Martino Testimony; Ex. C, McCarthy Affidavit.]

94. Generally, SG&A Efficiencies relate to savings from reducing headcount, outside services, and associated costs (*e.g.*, employee benefits, real estate, information technology).

[21] Aetna expects to achieve $236 million in 2016, $763 million in 2017, and $1.4 billion in 2018. Through 2019, the cumulative efficiencies are expected to total $3.9 billion. [Ex. C, McCarthy Affidavit.]

These savings are identified with the following areas: Corporate, Retail, Employer Group, Healthcare Services, and Shared Services. The largest area of SG&A Efficiencies arises in the Corporate area by reducing duplicative corporate and administrative functions such as finance, legal, marketing, strategy, human resources, and similar functions. Savings from Shared Services mostly come from streamlining services like information technology and claims management. [Martino Testimony; Ex. C, McCarthy Affidavit; McCarthy Testimony.]

95. Medical Cost Efficiencies result from a reduction in the direct cost of providing health care to members. These savings relate to either greater efficiency of care (through the Medical Management function) or alignment of member care payments. The largest areas of efficiencies come from merging the medical management function, aligning Aetna's and Humana's health care network and payment structure ("Network Efficiencies") and greater capture of pharmaceutical rebates ("Pharmacy Efficiencies"). Aetna's members who are self-insured will benefit directly from lower health care costs associated with the Medical Cost Efficiencies, as medical payments are billed directly to self-insured employers. [Martino Testimony; Ex. C, McCarthy Affidavit; McCarthy Testimony.]

96. Aetna recently demonstrated its ability not only to meet its targeted cost savings, but to actually surpass its own estimates. Indeed, Aetna achieved similar types of efficiencies from its acquisition of Coventry in 2012. In fact, by 2014 Aetna had already greatly exceeded the estimates made in 2012. [Martino Testimony; Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. P, Preliminary White Paper on Efficiencies in Aetna/Humana Merger.]

97. Aetna members will benefit from lower pricing associated with Aetna having achieved Medical Cost Efficiencies. It is also important to note that the quality of Aetna's offerings is expected to improve with the merger, leading to better health care for Aetna and

Humana members. Looking back at the Coventry merger, the alignment of Aetna and Coventry's medical management practices resulted in an overall improvement in health plan quality as measured by both the Healthcare Effectiveness Data and Information Set (HEDIS®) and CMS Star ratings. By following the same post-merger integration strategy, Aetna expects this to hold true for the Aetna-Humana transaction – the merged company will analyze their combined proprietary cost and quality data to identify and implement cost and quality improvements that could not have otherwise been implemented. In short, the proposed transaction is expected to achieve significant cost savings and quality improvements that will inure to the benefit of Aetna and Humana customers both nationally and in Missouri. [Ex. C, McCarthy Affidavit; McCarthy Testimony; Ex. P, Preliminary White Paper on Efficiencies in Aetna/Humana Merger.]

RECOMMENDATION TO DIRECTOR

98. For the reasons set forth above, I hereby find and conclude that there is no substantial evidence that the effect of the proposed transaction may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly therein. Accordingly, I hereby recommend to the Director that no order should be issued pursuant to 382.095.5, RSMo.

So ordered, signed and official seal affixed this ____ day of May, 2016.

_____

Mary S. Erickson, Hearing Officer,
Missouri Department of Insurance, Financial Institutions and Professional Registration